



2017

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DOI: <http://dx.doi.org/10.18590/mjm.2017.vol3.iss1.3>

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Recommended Citation

Shapiro, Joseph I. (2017) "Education of Nurse Practitioners and Physician Assistants; What Role, if any, for Physicians in Determining Their Scope of Practice?," *Marshall Journal of Medicine*: Vol. 3: Iss. 1, Article 3.

DOI: <http://dx.doi.org/10.18590/mjm.2017.vol3.iss1.3>

Available at: <http://mds.marshall.edu/mjm/vol3/iss1/3>

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Education of nurse practitioners and physician assistants; what role, if any, for physicians in determining their scope of practice?

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The author has no conflicts of interest to disclose.

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Abstract

Recent changes in legislation allow for non-physicians to independently perform many of the duties previously restricted to physicians. There are potentially benefits to these changes, but the author is concerned that some of the attributes of physicians induced by the long and rigorous training embedded in the profession may be absent in this new, independent health-care work force.

Keywords

nurse practitioners, physician assistants, midlevels, prescriptive authority

Editorial

Let me begin with two disclaimers. The first is that the opinions that I'm going to share are mine and mine alone. They aren't a compilation of physicians' opinions in general nor are they an official viewpoint of the Joan C. Edwards School of Medicine, an institution that I have the honor to represent on many occasions (but this isn't one of them). The second is that I am not "against" nurses or any of the myriad of professional organizations whose functions allow doctors to provide health care. It has been my experience that doctors can do very, very little on their own. During my (long) career, I have personally benefitted tremendously from these collaborations as well as work and personal relationships. The expression "some of my best friends are nurses" doesn't cover it; my real "partners" in delivering health care have been the nurses and staff working within hospitals or within my specialized practice areas, namely hemodialysis and transplantation. My spouse was a nurse earlier in her career, and I met her at work.

Those disclaimers stated, I have become concerned about the increasingly independent practice of so called mid-levels including nurse practitioners, and physician assistants as well as a move to doctoral level training degree programs in these disciplines. Quite simply, I worry that the demarcation lines of the medical profession have become blurred in a manner that could become problematic. I will expand on this point in a few moments.

Let me first digress to the selection, training and evaluation that are applied to our physician workforce. Medical students are selected from our most academically successful college graduates. A rigorous and demanding premedical curriculum is often added to an equally demanding major in an unrelated (or only partially related) field. Satisfactory scores on a comprehensive standardized test, the medical college admission test (MCAT), are often part of the admission process. However, in addition to these academic achievements, applicants are scrutinized for the humanism and ethics. All medical schools that I'm aware of employ a personal interview (or multiple interviews) as part of the application process.¹ Admissions committees consisting of physicians, scientists, staff and lay members of the community deliberate as to whom we will offer an opportunity to matriculate. At the Joan C. Edwards School of Medicine, we offer this opportunity to only 40% of our in-state and < 5% of our out-of-state applicants that meet our published minimum criteria for premedical performance each year.²

Once students are accepted to medical school, the process intensifies. We require that our students master a tremendous amount of academic material in order to be promoted through the stages of their training. We also insist that they develop and achieve competencies beyond medical knowledge in areas that our faculty and accrediting body deem essential for practice (e.g., communication, professionalism). Perhaps most importantly, our faculty and staff directly observe the students in the way that they interact with patients and other health care team members throughout their four years of medical school education. Only those students that we feel will practice medicine at a level commensurate with the requirements of our profession are allowed to graduate. At each of the six medical schools that I have been associated with, some students were not allowed to graduate despite achieving adequate scores in medical knowledge because of such deficiencies. Although this may have been tragic for such a student, our profession feels that patient safety must be our primary concern.³

Following medical school, graduates must perform additional training in order to practice independently. Graduation from medical school and satisfactory performance on the first two stages of the medical licensure exam (MLE) allows for a training license to be granted. With such a license, resident physicians train for an additional 3-7 years under the supervision of more senior physicians in order to qualify to sit for comprehensive board certification examinations. During residency training, progression in a multitude of areas is assessed and documented as part of the formal program. Again, some physicians are not allowed to complete these residency programs because of unsatisfactory progress in key areas. Once a resident physician graduates and achieves board certification, most boards now require periodic recertification every 5-10 years. On top of these demands, most hospitals and multi-specialty practices (e.g., a medical school faculty) have their own additional requirements for physician practitioners. Truly, it is a difficult and never-ending journey. I would argue that the public should demand no less, but perhaps that is where my problem lies.

Without getting into specifics, the academic demands for people to achieve a nurse practitioner or physician assistant degree are much less. Programs are, to the very best of my knowledge, substantially less selective and much, much shorter. At present in WV, many, perhaps even the majority of nurse practitioners, received their degree from on-line programs. Moreover, WV now, like a number of states, allow nurse practitioners to practice with prescriptive authority without the need for collaboration with a physician after two years.⁴ I must say that the idea that the practice of medicine could be learned “on-line” is disturbing to me on a personal level. In fact, I’m deeply disturbed that some individuals with such an abbreviated training would want to practice independently. Although my nurse practitioner colleagues might argue that they “aren’t practicing medicine”, the lines have become pretty blurred, at least to me.

With this background, I am particularly disturbed about the “idea” of the doctor of nurse practice degree. Why? Is this a necessary degree for educational purposes? Ph.D. degrees have been granted in nursing for a number of years, and many academic nurses have achieved Ph.D. degrees in other fields (e.g., physiology, psychology). At the risk of sounding jaundiced, I fear that the purpose behind this doctor of nurse practice is simply to confuse patients that they are seeing a physician. Again, one might argue that they aren’t practicing medicine, but a patient

goes to an independent office, gets evaluated by someone who introduces themselves as doctor, gets a slip for lab tests and prescriptions. . . . Well, it seems a lot like practicing medicine to me. I would expect that as a minimum, such doctoral degree holders should be expected to inform patients that their credentials are different from those of an M.D. or D.O. whose path to independent practice is, as discussed above, quite different.

At this point, I have to ask myself why the public clearly supports a move towards a broader practice of professionals who have abbreviated training compared with physicians. The answer, of course, involves money as it always does. Clearly, the expectation is that practitioners who train for 4 or 5 years rather than 11-17 years will demand less payment for their time and effort. In addition, it is also expected that nurse-practitioners will be willing to practice in rural settings that are not currently well serviced by physicians, also decreasing the net cost of providing care to patients. Quite frankly, I just don't know if these benefits will be realized, and the actual data has not yet shown that this is true.⁵⁻⁷ Although physicians are amongst the highest paid members of our society, their compensation accounts for a relatively modest portion of the cost of health care. Hospitalizations, laboratory tests and imaging studies along with pharmaceuticals each account for far more than physician professional costs. Will independent nurse practitioners or physician assistants order less expensive tests? Will they refer less to specialty physicians? Conversely, there are also costs to any increase in medical "mistakes" (e.g., wrong diagnosis, wrong therapy). Will these be more frequent when nurse practitioners practice without physician collaboration? The simple truth is that we don't know the answers to these questions.

There is another, unspoken, assumption that I'd like to articulate and debunk. I fear that our public believes that there is relatively little risk to having health care providers like nurse practitioners practice "primary care" as the "real" demands of medicine and surgery are specialty care and procedures, the things that only doctors will do. This just isn't true. As a specialist, I firmly believe that the greatest challenge is primary care where literally anything can happen. In a specialty office, the differential diagnosis is almost always more limited. In fact, I believe this specialty setting is where nurse practitioners and physician assistants, operating in collaboration with specialty physicians, probably can save money and provide excellent care. However I maintain that it is in general practice (or primary care) where I would expect that abbreviated training of nurse practitioners who subsequently practice independently could expose our public to the greatest risk.

As I said at the beginning of this editorial, I am sharing my own opinion, and I must admit that I'm a product of my training and indoctrination into the practice of medicine over these past 40 years. I believe that my extensive, long, and difficult training was necessary to make me the physician that I am. Our profession demands a lot from physicians, throughout their training and their practice as they sacrifice enormous amounts of time not to mention incur tremendous financial debt all for the privilege of serving as physicians. I remain concerned that health care providers from the nurse practitioner and physician assistant professions, practicing independently, will not provide the same level of dedication and skill that our public has grown accustomed to.

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